(SEAL)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION 1

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SERVICE

In reply refer to: SRS/MS #76-4

To: ALL STATE PUBLIC WELFARE ADMINISTRATORS
ATTENTION: STATE MEDICAL CARE DIRECTORS

SUBJECT: Title XIX—Fair Hearings—Requirement for Advance Notice and Continuation of Assistance —45 CFR 205.10(a)(5) and Fair Hearing Guides 6-30-20E and F

This letter is in response to inquiries from several States about the applicability of the "advance notice" and "continuation of assistance" requirements in the fair hearing regulation (45 CFR 205.10(a)(5)) to medical assistance programs under Title XIX.

Questions most frequently asked on these topics relate to a recipient's rights to advance notice and continuation of assistance by the agency when he is aggrieved by an agency action affecting suspension, reduction or termination of such assistance; for example, when he is found no longer to need skilled nursing home care or a particular kind of medication. The questions relate specifically to actions resulting from utilization review programs.

The "advance notice" and "continuation of assistance" requirements are not applicable when the change is prescribed by the patient's physician, because a physician's decision that his patient does or does not need a specified

type of medical care or service is not a decision of the medical assistance agency.

Utilization review committees are required to safeguard against unnecessary utilization and improper payment for care and services. They make recommendations about the appropriateness of care but do not issue orders for patients. Any utilization review recommendation differing from a current treatment program should be immediately referred to the attending physician.

a. Subsequent action by the physician whether or not in conformity with the utilization review recommendation is not agency action and the patient who disagrees with the physician's decision is not entitled to "advance notice" and "continuation of assistance."

b. Differences between the utilization review recommendation and the attending physician that cannot be reconciled may result in an agency decision to discontinue payment. The requirements of advance notice and continuation of assistance are applicable.

The medical assistance agency is obliged to give advance notice of any action it proposes to reduce, suspend, or terminate payment for medical services under the plan, when factors other than medical need are involved. This would apply when the agency has information that indicates that the recipient no longer meets one or more eligibility requirements; for example, that his income or resources have increased so that he is no longer eligible or that his financial eligibility s reduced.

While the individual has a right to a fair hearing in financial and medical assistance under circumstances identified in 45 CFR 205.10(a)(3), a change in medical care ordered by the patients physician does not represent an *agency proposal* to terminate, suspend or reduce the assistance payment. If a patient disagrees with his physician's determination of "medical necessity" for a specific service,

his recourse is to the practitioner or his professional association, not to the medical assistance agency.

When there has been a professional judgment that a specific medical service is no longer medically necessary, it is not expected that the agency will immediately cease to be obligated to pay for the previously needed service. Federal sharing in the cost of the service may continue for a reasonable period while other care is being arranged. The medical assistance agency (or another agency with which it has arranged for social services) should assist the recipient in obtaining the type of care that is professionally recommended, from a provider of his choice (45 CFR 249.11).

The rights of a provider of services to payment for care provided to an individual eligible for medical assistance after such care has been professionally determined not to be necessary depend on State law and agency policy. In cases of controversy, the issue must be resolved as one between the provider and the agency, not one between the recipient of medical assistance and the medical assistance agency.

Sincerely yours,

ALFRED G. FUOROLI
Alfred G. Fuoroli

Associate Regional Commissioner
for Medical Services